EXAMPLE FOR AMOUNT ADMINISTERED (AA)

Medications as listed on MAR for assessment period of 8/11/94-8/17/94

A. Lanoxin 0.125 mg. daily p.o.
B. Haldol 1 mg. liquid q8 hrs PRN p.o. (received 2 times in last 7 days)
C. Ampicillin 250 mg. q 6 hrs liquid p.o.
D. Acetaminophen 650 mg. QID p.o. (pharmacy supplies two 325 mg. tablets)
E. Acetaminophen 325 mg. 3 tabs q3-4 hrs PRN for pain p.o. (received 5 times in last 7 days)
F. Humulin N 15 U before breakfast daily SQ
G. Check blood sugar daily at 4 p.m. Sliding scale insulin: Humulin R 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/94 for BS of 255; 5 units given on 8/13/94 for BS of 233; 10 units given on 8/17/94 for BS of 305)
H. Elase ointment to necrotic tissue on left heel TID
I. Diazepam 3 mg. HS p.o.
J. Dilantin 300 mg. HS p.o.
K. Metamucil powder 1 tbsp. in a.m. p.o.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5.PRN-n	6. NDC Codes
Lanoxin 0.125 mg.	1	1D	1		
Haldol 1 mg.	1	PR	.5cc		
Ampicillin 250 mg.	1	6H	5ml		
Acetaminophen 650 mg.	1	4D	2		
Acetaminophen 325 mg . 3 tabs	1	PR	3		
Humulin N 15 U	5	1D	15U		
Humulin R 5 U	5	PR	5U		
Humulin R 10 U	5	PR	10U		
Elase ointment	7	3D	999		
Diazepam 3 mg.	1	1D	1.5		
Dilantin 300 mg.	1	1D	3		
Metamucil powder 1 tbsp.	1	1D	999		

5. PRN-number of doses (PRN-n). The PRN-n column is only completed for medications that have a route of administration coded as PR. Record the **number of times** in the past seven days that each medication coded as PR was given. STAT medications are recorded as a PRN medication. Remember, if a PRN medication was **not** given in the past seven days, it should not be listed in Section U.

EXAMPLE FOR PRN-number (PRN-n)

Medications as listed on MAR for assessment period of 8/11/94-8/17/94

A. Mylanta 15 cc after meals PRN p.o. (administered 12 times in last 7 days)
B. Haldol 1 mg. liquid q8 hrs PRN p.o. (administered 2 times in last 7 days)
C. Hydrocortisone cream 1% PRN to back and chest (administered 5 times in last 7 days)
D. Lasix 80 mg. IV STAT
E. Check blood sugar daily at 4 p.m. Sliding scale insulin: Humulin R 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/94 for BS of 255; 5 units given on 8/13/94 for BS of 233; 10 units given on 8/17/94 for BS of 305
F. Nitroglycerin 0.3 mg 1 tab SL for chest pain; repeat 2 times at 5 minute intervals if pain is not relieved (given on 8/12/94 once and another five minutes following)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5.PRN-n	6. NDC Codes
Mylanta 15 cc	1	PR	15cc	12	
Haldol 1 mg .	1	PR	0.5cc	2	
Hydrocortisone cream 1%	7	PR	999	5	
Lasix 80 mg.	4	PR	8cc	1	
Humulin R 5 Units	5	PR	5U	2	
Humulin R 10 Units	5	PR	10U	1	
Nitroglycerin 0.3 mg.	2	PR	1	2	

EXAMPLE FOR NDC CODES

Medications as listed on MAR for assessment period of 8/11/94-8/17/94

A. Lanoxin 0.125 mg. daily p.o.
B. Haldol 1 mg. liquid q8 hrs PRN p.o. (administered 2 times in last 7 days)
C. Ampicillin 250 mg. q 6 hrs. liquid p.o.
D. Acetaminophen 650 mg. QID p.o. (pharmacy supplies two 325 mg. tablets)
F. Humulin N 15 U before breakfast daily SQ
G. Check blood sugar daily at 4 p.m. Sliding scale insulin: Humulin R 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/94 for BS of 255; 5 units given on 8/13/94 for BS of 233; 10 units given on 8/17/94 for BS of 305).
H. Transderm Nitro 1 Patch QD
I. Lasix 80 mg. IV STAT
J. Diazepam 3 mg. HS p.o.
K. Dilantin 300 mg. HS p.o.

1. Medication Name and Dose Ordered	2.RA	3. Freq	4. AA	5.PRN-n	6. NDC Codes
Lanoxin 0.125 mg.	1	1D	1		00081024 2
Haldol 1 mg.	1	PR	.5cc	2	00045025 0
Ampicillin 250 mg.	1	6H	5ml		00047230 2
Acetaminophen 650 mg.	1	4D	2		00781129 4
Humulin N 15 U	5	1D	15U		00028315
Humulin R 5 U	5	PR	5U	2	00028215
Humulin R 10 U	5	PR	10U	1	00028215
Transderm Nitro 1 patch	7	1D	999		00083202 5
Lasix 80 mg.	4	PR	8cc	1	00039006 3
Diazepam 3 mg.	1	1D	1.5		00364077 4
Dilantin 300 mg.	1	1D	3		00071036 2

Coding Exercises for Section U

Complete Section U for the following medications during a 7 day period (9/1/94-9/7/94):

1. Inderal 40 mg. BID p.o.
2. Sinemet 10/100 TID p.o.
3. Artificial Tears 1 drop OU QID
4. Anusol HC suppository 1 PRN (given 1 time in last seven days)
5. Amoxicillin 500 mg q 6 hrs per tube
6. Benylin cough syrup 2 tbs. PRN p.o. (given 10 times in last seven days)
7. Darvocet-N 100 2 tabs q 4-6 hrs PRN p.o. (given 5 times in last seven days)
8. Heparin lock flush 10 U daily
9. Ditropan syrup 2.5 mg daily p.o.
10. Nitrotransdermal .4 mg 1 patch daily
11. Novolin N 24 U before breakfast SQ
12. Check blood sugar before breakfast. Sliding scale insulin: Novolin R 10 units if blood sugar over 200. (10 units given on 2 days in last 7 days)
13. Questran 1 packet with each meal p.o.
14. Quinine sulfate 325 mg. HS
15. Coumadin 2.5 mg daily p.o. (discontinued 9/3/94)
16. Coumadin 5 mg. daily p.o. (ordered to start on 9/4/94)
17. Maalox 15 cc PRN for indigestion p.o. (not administered in last 7 days)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5.PRN-n	6. NDC Codes

Compare your responses to the coding exercises with the responses on the next page.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Inderal 40 mg.	1	2D	1		00046042 4
Sinemet 10/100	1	3D	1		00006064 7
Artificial Tears 1 drop	7	4D	999		00349861 5
Anusol HC suppository 1	6	PR	1	1	00071108 8
Amoxicillin 500 mg	9	6H	10 ml		00304058 7
Benylin cough syrup 2 Tbs.	1	PR	30 cc	10	00071219 5
Darvocet-N 100 2 tabs	1	PR	2	5	00002036 3
Heparin lock flush 10 U	4	1D	1 ml		00469300 1
Ditropan syrup 2.5 mg	1	1D	2.5ml		00008813 7 3
Nitrotransdermal .4 mg.	7	1D	999		47202282 3 2
Novolin N 24 U	5	1D	24 U		00031834
Novolin R 10 U	5	PR	10 U	2	00031833
Questran 1 packet	1	3D	999		00087058 0
Quinine sulfate 325 mg.	1	1D	1		00020629
Coumadin 2.5 mg.	1	1D	1		00056017 6
Coumadin 5 mg.	1	1D	1		00056017 2

CHAPTER 4: PROCEDURES FOR COMPLETING THE RESIDENT ASSESSMENT PROTOCOLS (RAPs)

This chapter gives instructions on using the Resident Assessment Protocols (RAPs) to assess conditions identified by the Minimum Data Set (MDS) triggering mechanism. The goal of the RAPs is to guide the interdisciplinary team through a structured comprehensive assessment of a resident's functional status. Functional status differs from medical or clinical status in that the whole of a person's life is reviewed with the intent of assisting that person to function at his or her highest practicable level of well-being. Going through the RAI process will help staff set resident-specific objectives in order to meet the physical, mental and psychosocial needs of residents.

4.1 What are the Resident Assessment Protocols (RAPs)?

The MDS alone does not provide a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident problems, strengths, and preferences. The RAPs are problem-oriented frameworks for additional assessment based on problem identification items (triggered conditions). They form a critical link to decisions about care planning. The RAP Guidelines provide guidance on how to synthesize assessment information within a comprehensive assessment. The Triggers target conditions for additional assessment and review, as warranted by MDS item responses; the RAP Guidelines help facility staff evaluate "triggered" conditions.

There are 18 RAPs in Version 2.0 of the RAI. The RAPs in the RAI cover the majority of areas that are addressed in a typical nursing home resident's care plan. The RAPs were created by clinical experts in each of the RAP areas.

The care delivery system in a facility is complex yet critical to successful resident care outcomes. It is guided by both professional standards of practice and regulatory requirements. The basis of care delivery is the process of assessment and care planning. Documentation of this process (to ensure continuity of care) is also necessary.

The RAI (MDS and RAPs) is an integral part of this process. It ensures that facility staff collect minimum, standardized assessment data for each resident at regular intervals. The main intent is to drive the development of an individualized plan of care based on the identified needs, strengths and preferences of the resident.

It is helpful to think of the RAI as a package. The MDS identifies actual or potential problem areas. The RAPs provide further assessment of the "triggered" areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAPs to analyze assessment findings and then "chart your thinking". It is important that the RAP documentation include the causal or unique risk factors for decline or lack of improvement. The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: 1) improvement where possible, or 2) maintenance and prevention of avoidable declines.

RAPs function as decision facilitators, which means they lead to a more thorough understanding of possible problem situations by providing educational insight and structure to the assessment process. The RAPs will give the interdisciplinary team a sound basis for the development of the resident's care plan. After the comprehensive assessment process is completed, the interdisciplinary team will be able to decide if:

- The resident has a troubling condition that warrants intervention, and addressing this problem is a necessary condition for other functional problems to be successfully addressed;
- Improvement of the resident's functioning in one or more areas is possible;
- Improvement is not likely, but the present level of functioning should be preserved as long as possible, with rates of decline minimized over time;
- The resident is at risk of decline and efforts should emphasize slowing or minimizing decline, and avoiding functional complications (e.g., contractures, pain); or
- The central issues of care revolve around symptom relief and other palliative measures during the last months of life.

OBRA 1987 mandated that facilities provide necessary care and services to help each resident attain or maintain their highest practicable well-being. Facilities must ensure that residents improve when possible and do not deteriorate unless the resident's clinical condition demonstrates that the decline was unavoidable.

4.2 How are the RAPs Organized?

There are four parts to each RAP:

Section I - The Problem gives general information about how a condition affects the nursing home population. The Problem statement often describes the focus or objectives of the protocol. It is important when reviewing a "triggered" RAP not to overlook information in the Problem section. Although Section III - The Guidelines contain the "detail", the Problem section should be reviewed for information relevant to the assessment.

Section II - The Triggers identify one or a combination of MDS item responses specific to a resident that alert the assessor to the resident's possible problems, needs, or strengths. The specific MDS response indicates that clinical factors are present that may or may not represent a condition that should be addressed in the care plan. Triggers merely "flag" conditions necessary for the interdisciplinary team members to consider in making care planning decisions.

When the resident's status on a particular MDS item(s) matches one of the "triggers" for a RAP, the RAP is "triggered" and a review (with the possibility of additional data gathering and assessment) is required using the RAP Guidelines.

Section III - The Guidelines present comprehensive information for evaluating factors that may cause, contribute to, or exacerbate the triggered condition. The Guidelines help facility staff decide if a triggered condition actually does limit the resident's functional status or if the resident is at particular risk of developing the condition.

If the condition is found to be a problem for the resident, the Guidelines will assist the interdisciplinary team in determining if the problem can be eliminated or reversed, or if special care must be taken to maintain a resident at his or her current level of functioning.

In addition to identifying causes or risk factors that contribute to the resident's problem, the Guidelines may assist the interdisciplinary team to:

- Find associated causes and effects. Sometimes a problem condition (e.g., falls) is associated with just one specific cause (e.g., new drug that caused dizziness). More often, a problem (e.g., falls) stems from a combination of multiple factors (e.g., new drug; resident forgot walker; bed too high, etc.).
- Determine if multiple triggered conditions are related.
- Suggest a need to get more information about a resident's condition from the resident, resident's family, responsible party, attending physician, direct care staff, rehabilitative staff, laboratory and diagnostic tests, consulting psychiatrist, etc.
- Determine if a resident is a good candidate for rehabilitative interventions.
- Identify the need for a referral to an expert in an area of resident need.
- Begin to formulate care plan goals and approaches.

Section IV - The RAP Key has two parts. The first part is a review of the items on the MDS that triggered a review of the RAP. The second part is a summary, but sometimes also provides a clarification of the information in the Guidelines section of the RAP. The RAP Key should be used as a reference, but does not take the place of the main body of the RAP.

There are 18 RAPs in the Resident Assessment Instrument, Version 2.0[1]:

Delirium
Cognitive Loss/Dementia
Visual Function
Communication
ADL Function /Rehabilitation
Urinary Incontinence and Indwelling Catheter
Psychosocial Well-Being
Mood State
Behavior Symptoms
Activities
Falls
Nutritional Status
Feeding Tubes
Dehydration/Fluid Maintenance
Dental Care
Pressure Ulcers
Psychotropic Drug Use
Physical Restraints

4.3 What does the RAP Process Involve?

There are various models for completing the RAP in-depth assessment process for a resident with a particular problem. Assessment of the resident in "triggered" RAP areas may be performed solely by the RN Coordinator (i.e., as the RAI must be completed or coordinated by an RN per the OBRA statute). Generally, the RAPs will be completed by various members of clinical disciplines as appropriate to the needs of individual residents. Facilities may also establish procedures in which certain RAPs are always reviewed by a particular discipline (e.g., the dietician completes the Nutritional Status and Feeding Tube RAPs, if triggered). The interdisciplinary team may also review RAP Guidelines in a joint manner and have the assessment process flow seamlessly into care planning. There are no mandates regarding the "process" of how facility staff use the RAPs. Rather, facility staff should be creative and experiment until they find "what works" most efficiently and effectively for them in achieving the desired outcome (i.e.,

[1] The names of the RAPs in Version 2.0 are unchanged from the original version, as are the RAP Guidelines. The triggers in almost all of the RAPs have been revised, however.

a sound and comprehensive assessment that is used to develop an individualized plan of care for each resident).

The RAP process includes the following steps:

1. Facility staff use the RAI triggering mechanism to determine which RAP problem areas require review and additional assessment. The triggered conditions are indicated in the appropriate column on the RAP Summary form.

2. Staff assess the resident in the areas that have been triggered and are guided by the RAPs and other assessment information as needed, to determine the nature of the problem and understand the causes specific to the resident.

3. Staff document key findings regarding the resident's status based on the RAP review. RAP assessment documentation should generally describe:

   — Nature of the condition (may include presence or lack of objective data and subjective complaints).

   — Complications and risk factors that affect the staff's decision to proceed to care planning.

   — Factors that must be considered in developing individualized care plan interventions.

   — Need for referrals or further evaluation by appropriate health professionals.

   Documentation about the resident's condition should support clinical decision-making regarding whether to proceed with a care plan for a triggered condition and the type(s) of care plan interventions that are appropriate for a particular resident.

   The decision to proceed to care planning should also be indicated in the appropriate column on the RAP Summary form.

4. Based on the review of assessment information, the interdisciplinary team decides whether or not the triggered condition affects the resident's functional status or well-being and warrants a care plan intervention.

5. The interdisciplinary team, in conjunction with the wishes of the resident, resident's family, and attending physician develop, revise, or continue the care plan based on this comprehensive assessment.

4.4 Identifying Need for Further Resident Assessment by Triggering RAP Conditions (RAP Process - Step 1)

A RAP may have several MDS items or sets of items that are defined as triggers. Only one of the trigger definitions must be present for a RAP to be triggered, although for many RAPs, each of the specific trigger items that are present must be investigated (e.g., address each of the potential side effects for the Psychotropic Drug Use RAP). Note that the concept of "automatic" and "potential" triggers used in the original version of the RAI has been eliminated. In Version 2.0, there are no "potential" triggers, or situations in which a symbol on the Trigger Legend does not require RAP review.

The trigger definitions can be found in:

- Section II of each RAP;
- The RAP Key found at the end of each RAP; and
- The RAP Trigger Legend.

The **Trigger Legend is a 2 page form** that summarizes all of the triggers for the 18 RAPs. **It is not a required form that must be maintained in the resident's clinical record.** Rather, it is a worksheet that may be used by the interdisciplinary team members to determine which RAPs are triggered from a completed MDS form.

Many facilities use automated systems instead of the Trigger Legend form to trigger RAPs. The resulting set of triggered RAPs that is generated by your home's software program should be matched against the trigger definitions to make sure that triggered RAPs have been correctly identified.[2] HCFA has also developed test files for facility validation of a software program's triggering logic. It is the facility's responsibility to ensure that the software is triggering correctly. At a minimum, ask whether the triggered RAPs are what you would have expected. Did the software miss some RAPs you thought should have been triggered (do some of the RAPs seem to be missing); are there others triggered that you did not expect?

To identify the triggered RAPs using the Trigger Legend:

1. Compare the completed MDS with the Trigger Legend to determine which RAPs are "triggered" for review. Begin by looking at the **KEY** in the upper left corner of the Trigger Legend form. Note that there are four possible ways for a RAP to trigger:

   The first, indicated by a solid black circle, is the predominant method and requires only one MDS item to trigger a RAP.

[2]This process should be performed on a sample of assessment records any time changes have been made in the MDS software.

The second, indicated by a "2" within a solid circle, requires two MDS items to trigger a RAP.

The third, indicated by an asterisk (*), requires one of three types of psychotropic medications (antipsychotic, antianxiety or antidepressant), and one other item in the Psychotropic Drug Use column indicated by a solid black circle.

The fourth is indicated by a small case "a" within a circle. This is a special ADL trigger that will focus the RAP review on rehabilitation or on the maintenance of current function.

Find the ADL -Rehabilitation Trigger A and the ADL-Maintenance Trigger B columns by scanning the top of the Trigger Legend form. Notice each ADL column title is marked with a circled "a".

If there are solid circles in both ADL columns, the ADL Maintenance column will take precedence.

2. Look at the two left columns of the Trigger Legend. These columns list the letter and number codes as well as the name of the MDS items to be considered. The third column lists the specific resident codes that will trigger a RAP. The remaining columns list the individual RAP titles.

To identify a triggered RAP, match the resident's MDS item responses with the "Code" column. If there is a "match", follow horizontally to the right until a trigger is indicated by one of the key symbols. If, for example, there is a solid circle in the column, the RAP titled at the top of that column is "triggered". This means that further assessment using the RAP Guideline is required for that particular condition.

3. Note which RAPs are triggered by particular MDS items. If desired, circle or highlight the trigger indicator or the title of the column.

4. Continue down the left column of the Trigger Legend matching recorded MDS item responses with trigger definitions until all triggered RAPs have been identified.

5. When the Trigger Legend review is completed, document on the RAP Summary form which RAPs triggered by checking the boxes in the column titled "Check if Triggered".

EXAMPLES

When Mrs. D. returns to her room after eating breakfast, she cannot recall eating breakfast, and always asks the nurse when breakfast will be served. MDS item Short Term Memory, B2a, has been coded 1 (Memory Problem), and the Cognitive Loss/Dementia RAP is triggered for further assessment.

Mr. F. is independent in cognitive skills for daily decision-making. His transferring ability varies throughout each day. He receives no assistance at some times and heavy weight-bearing assistance of one person at other times. The MDS item Decision Making, B4, is coded 0 (Independent). The MDS item Transferring, G1bA, is coded 3 (Limited Assistance). The ADL-Rehabilitation RAP is triggered for further assessment, focusing on a possible rehabilitative intervention. Rationale for trigger: Mr. F. has good cognitive skills for learning new ways to function and realize his potential.

Mr. P. is receiving an antipsychotic medication two times per day. He has fallen within the last 30 days. The MDS item Antipsychotics, O4a, is coded 7 (Received 7 days a week). The MDS item Falls (in past 30 days), J4a, is checked. The Psychotropic Drug Use RAP is triggered for further assessment. (Note: Because J4a is checked, the Falls RAP will also be triggered.)

Mrs. T. is highly involved in activities of the facility. When structured activities are not scheduled, she keeps busy reading, crocheting and writing a journal. Mrs. T. awakens early in the morning and rarely takes a nap. MDS item Awake Mornings, N1a, is checked. MDS item Involved in Activities, N2, is coded 0 (most of time). Both of these MDS items are required to trigger the Activities RAP; these factors in combination suggest that the focus of the assessment should be on reviewing the current activities plan.

Mrs. C. is limited in bed mobility (MDS item G1aA), with a physical restraint used during part of the day. The presence of any of these items is sufficient to trigger the Pressure Ulcer RAP, focusing on issues of problem avoidance in the future. (Note: other RAPs triggered include ADLs and Physical Restraints.)

Different types of triggers can change the focus of the RAP review. There are four types of triggers:

1. **Potential Problems** - Those factors that suggest the presence of a problem that warrants additional assessment and consideration of a care plan intervention. These are usually "narrowly" defined as factors that warrant additional assessment. They include clinical factors commonly seen as indicative of possible underlying problems and consequently have generally been well understood by facility staff members. Examples include the

presence of a pressure ulcer or use of a trunk restraint, both of which indicate the need for further review to determine what type of intervention is appropriate or whether underlying behavioral symptoms can be minimized or eliminated by treatment of the underlying cause (e.g., agitated depression).

2. **Broad Screening Triggers** - These are factors that assist staff to identify hard to diagnose problems. Because some problems are often difficult to assess in the elderly nursing home population, certain triggers have been "broadly" defined and consequently may have a fair number of "false positives" (i.e., the resident may trigger a RAP which is not automatically representative of a problem for the resident). Examples include factors related to delirium or dehydration. At the same time, experience has shown that many residents who have these problems were not identified prior to having triggered for review. Thus careful consideration of these triggered conditions is warranted.

3. **Prevention of Problems** - Those factors that assist staff to identify residents at risk of developing particular problems. Examples include risk factors for falling or developing a pressure ulcer.

4. **Rehabilitation Potential** - Those factors that are aimed at identifying candidates with rehabilitation potential. Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths. In general, these factors suggest consideration of programs to improve a resident's functioning or minimize decline. For example, MDS item responses indicating "Resident believes he or she is capable of increased independence in at least some ADLs" (G8a) may focus the assessment and care plan on functional areas most important to the resident or on the area with the highest potential for improvement.

Facility staff who are assessing a resident whose condition "triggers" a RAP should know what item responses on the MDS triggered that RAP. This step is often missed, especially if someone other than the person(s) who completed the MDS reviews the Trigger Legend or the triggering is automated. Referring to the Triggers section of the RAP to identify relevant triggers can help to "steer" the assessment to factors particular to the individual resident. For example, if a staff member assigned to assess a resident who has fallen or is at risk for falls knows that the Falls RAP was triggered because the resident had been dizzy during the MDS assessment period (MDS item J1f - Dizziness was checked), the RAP review would include a focus on causal factors and interventions for dizziness. While reviewing the RAP, other factors may come to light regarding the resident's risk for falls, but knowing the trigger condition clarifies or possibly rules out certain avenues of approach to the resident's problem.

At the same time, there can also be a tendency to believe that the RAP review is limited to only those MDS items that triggered the RAP. Such a view is false and can lead to key causal factors being unnoticed and a less than appropriate plan of care being initiated. Many of the trigger conditions serve to initiate a more comprehensive review process including specific causal factors (as referenced in the Guidelines) that are to be considered relative to the resident's status.

4.5 Assessment of the Resident Whose Condition Triggered RAPs (RAP Process - Step 2)

"Reviewing" a triggered RAP means doing an in-depth assessment of a resident who has a particular clinical condition in terms of the potential need for care plan interventions. The RAP is used to organize or guide the assessment process so that information needed to fully understand the resident's condition is not overlooked.

The triggered RAPs are used to glean information that pertains to the resident's condition. While reviewing the RAP, facility staff consider what MDS items caused the RAP to trigger and what type of trigger it is (i.e., potential problem, broad screen, prevention of problem or rehabilitation potential). This focuses the review on information that will be helpful in deciding if a care plan intervention is necessary, and what type of intervention is appropriate.

The information in the RAP is used to supplement clinical judgment and stimulate creative thinking when attempting to understand or resolve difficult or confusing symptoms and their causes. The Guidelines are an aide, a tool, a starting point. It is the understanding and insight of members of the interdisciplinary team that will help integrate these factors into a meaningful resident assessment and care plan.

4.6 Decision-making and Documentation of the RAP Findings (RAP Process - Steps 3 and 4)

It is recommended that staff who have participated in the assessment and who have documented information about the resident's status for triggered RAPs be a part of the interdisciplinary team that develops the resident's care plan. The team, including the resident, family or resident representative, makes the final decision to proceed to address the "triggered" condition on the care plan.

In order to provide continuity of care for the resident and good communication to all persons involved in the resident's care, it is important that information from the assessment that led the team to their care planning decision be clearly documented.

It is not necessary to record all of the items referred to in the RAP Guidelines, listing all factors that do and do not apply. Rather, documentation should focus on key issues, which may include:

- Why will you address or not address specific conditions in the care plan?
- What is it about the conditions that may affect the resident's daily functioning?
- Why did you decide the resident is at risk, that improvement is possible, or that decline can be minimized?
- Why could the resident benefit from consultation with an expert in a particular area (e.g., gynecologist, psychologist, surgeon, speech pathologist)?

nursing care, ophthalmology evaluation to rule out visual field deficits, speech therapy referral. We will discuss Ms. E.'s care at nursing rounds tomorrow and develop a revised plan to address these issues.

EXAMPLE #2: This is an example of 1) documentation in the progress notes of the clinical record clarifying that a problem is present and has been discussed with the resident, and 2) another note that describes the beginning of a work-up to evaluate and treat causes of the problem.

8/21/95 PROBLEM: URINARY INCONTINENCE
Nursing note:

Mrs. D.'s clothing has been found wet during the night on 3 occasions in the past two weeks. Her nurse assistants have also found that she has been tucking washcloths in her underwear. I spoke with her this morning. She admitted that she has been having some urinary accidents for some time but was hiding them. She cried, saying, "I am so ashamed". I reassured her that although incontinence is not normal, it is common, and should be evaluated for possible treatments. I proceeded to review the type of step by step evaluation that could be done, some which could be done here at the home and, if necessary, she would see some specialists. Mrs. D. seemed relieved and asked me to call her daughter with the information. I spoke with Ms. D. who agreed with the evaluation. She said that she has been noticing a faint odor of urine when she visits, but her mother always denied any problems. Will contact physician.

G. Hope, RN

EXAMPLE #3: This is an example of a note in a clinical record that could be referenced on the RAP Summary form to substantiate a team's decision to proceed to care planning when a RAP is triggered.

8/30/95 PROBLEM: DELIRIUM
Physician Progress note:

Mr. F. has had new symptoms in the past week of altered perceptions (thinks someone keeps jumping through his window at night when the curtain moves and has hallucinations), restlessness (pacing) and agitation, and is more confused. A review of his medication sheet shows that his Digoxin dose was increased from 0.125 mg every other day to 0.25 mg. daily 2 weeks ago during an episode of congestive heart failure. His appetite has also decreased and he says food is making him sick. He is delusional in his thinking that his food is poisoned. Mr. F.'s exam is unremarkable for signs of an acute illness or other causes of delirium. His symptoms are consistent with probable digoxin toxicity. We will obtain a digoxin level in the morning. In the meantime, I have asked the nursing staff to hold the digoxin and encourage fluids until we reevaluate in the morning. I will temporarily put him on a low dose of Haldol 0.5 mg twice daily in order to reduce his delusions and distress. I will review his status daily with the goal of tapering him off the Haldol once his mental status returns to baseline.

Ben Todd, M.D.

8/30/95 PROBLEM: DELIRIUM
Nursing note:

Until the acute confusion subsides, Mr. F will receive close observation, monitoring of his intake with encouragement of fluids, cueing during ADLs to help him focus. He will be allowed to pace in the confines of the unit and restricted to the unit until his confusion resolves.
J. Doe, RN

EXAMPLE #4: This case illustrates summary documentation using RAP Guidelines to assess the resident's progress related to a previously noted condition, as well as the success of the care plan over time.

PROBLEM: PRESSURE ULCER OVER RIGHT TROCHANTER

Three months ago, Mr. H. developed a Stage III pressure ulcer over his right trochanter when he fell asleep on the spirals of a notebook while reading in bed (pressure). Mr. H. had been receiving Ambien 10mg at bedtime for sleep because he had difficulty falling asleep with a roommate who snores loudly. He was friendly with the roommate and did not want to switch rooms when the opportunity was offered. Deep sleep most likely contributed to his not responding to the spiral by shifting his weight. Mr. H. has since agreed to move in with a quieter roommate and discontinue the Ambien. We have been treating the ulcer with surgical debridement as necessary and wet to dry saline dressings three times daily, and the ulcer has cleared up nicely to a dime-size area with clean granulation tissue present. Dr. K. discontinued wet to dry dressings and it is being managed with a transparent dressing. Mr. H. is back to his usual activities and is adherent to his repositioning program when in bed. We will continue the current care plan.

EXAMPLE #5: This case illustrates documentation, using RAP Guidelines, to assess the progress of a long-stay resident who has chronic Urinary Incontinence AND Pressure Ulcer risk.

PROBLEM: LONG-STANDING URINARY INCONTINENCE AND PRESSURE ULCER RISK

Mr. F. is a severely demented gentleman who suffers from immobility secondary to dementia and disuse. He has tight contractures of his elbows, hips, knees, and ankles making toileting difficult. Mr. F. is frail, primarily bed- and recliner chair-bound. He is totally dependent on staff for care in ADLs, including eating. He has long-standing incontinence that has been managed for the past year with an external catheter to protect his skin (He has a history of rashes). When transferred he is always placed on pressure relieving devices. He receives a turning and positioning regimen. This regimen has been working and he is free of rashes and skin breakdown. We and his family are in agreement about continuing the current palliative approach to urinary incontinence and preventive approach to ulcer formation.

EXAMPLE #6: This example illustrates that it is not necessary to use the titles of the RAPs to document resident assessment information using RAP Guidelines. The most important goal of

documentation is to describe events in a way that everyone can understand what is happening to the resident.

PROBLEM: SIDE EFFECTS FROM MELLARIL

Mrs. L. has been disimpacted of hard, pasty stool twice during the last 6 days. Bowel elimination records show that she has been having infrequent movements. Staff say that she strains at stool. Mrs. L. has a long history of schizophrenia. Her psychosis has been managed with various antipsychotics over the years. Most recently (last 6 weeks) we switched her from Haldol to Mellaril 50 mg. TID daily for its sedative effects as she was agitated, wandering, and delusional. The Mellaril has calmed her down to the point that she is able to sit in on some unit activities without leaving them. The dose was then reduced but when symptoms recurred we went back to 50mg. TID. Her blood pressure has been stable at 138/86 - 146/90 and she has had no falls. The constipation is most likely related to the Mellaril. However, as her emotional state is currently stable and she is functioning better we will maintain the current dose, add Colace 100 mg. bid, assure adequate fluid intake, and consult with dietary for suggestions.

EXAMPLE #7: This is an example of a note that illustrates the assessment of multiple problems that were triggered by the MDS. The rationale for combining the assessment into one note is that the resident's risks, problems, causes, and treatments are all interrelated. On a RAP Summary form the following note could be referenced for several triggered RAPs: Falls, Psychotropic Drug Use, Cognitive Loss, Mood State.

PROBLEM: FALLS

Mrs. T.'s severely depressed mood has improved with Trazodone and involvement in a twice weekly expressive therapy group. She has been more attentive to her surroundings and has begun to socialize like her old self. She remains disoriented to time and continues to need many reminders for most tasks (her baseline). She has rejoined her baking group that meets every other day. Her appetite has picked up and she eats most meals that are offered. We are now concerned about 2 falling episodes this past week. She usually walks alone but is very slow. On Monday night she seemed to falter in the dining room but grabbed onto some chairs to steady herself. On Tuesday she was walking in the corridor with her daughter, faltered, and then her daughter caught her before she fell. Mrs. T. insisted that she felt O.K. She denied feeling dizzy or unsteady and said she just tripped over a chair. Yesterday, she fell to the floor in the dining room while getting up from a chair. She sustained no injuries but she was posturally hypotensive (See vital sign sheet). She was seen by Dr. R. who cut back on her Trazodone dose. We will monitor postural vital signs twice daily, and supervise all transfers and walking, and observe for changes in mood. She has been referred to PT for gait evaluation.

EXAMPLE #8: The following example illustrates how to document a situation when the resident functions at a consistent level over a long period of time. The MDS assessment always triggers the same RAP for the same reason, but the resident has shown neither improvement nor decline

4.7 Development or Revision of the Care Plan (RAP Process - Step 5)

Following the decision to address a "triggered" condition on the care plan, key staff or the interdisciplinary team should:

- Review the current care plan if the condition is already addressed and make changes, as needed, to reflect the new assessment; and
- Develop new care plan problems, goals and approaches as needed.

Staff may choose to combine related "triggered" conditions into a single care plan problem that will address the initial set of causal problems and related outcomes identified in the RAP review.

Chapter 5 will address the development of resident care plans in more detail.

4.8 Frequently Asked Questions on RAP Documentation

Q: "Is it necessary to complete a RAP review if a resident always triggers for the same RAP in the same way? For example, Mrs. Peterson always triggers for the Nutritional Status RAP because she often leaves 25% of her food uneaten at most meals. She is not a big eater, and prefers to snack throughout the day - not to mention the portions on the tray are quite large. Do we need to do the entire RAP each time?"

A: No, it is not necessary to always review and document RAP findings on subsequent assessments the way you would on the initial assessment. Triggers identify areas warranting further assessment. The RAP guides this assessment. In this example, further assessment may reveal a swallowing problem, chewing problem, delirium, activity endurance problem, or a healthy life time pattern. If Mrs. Peterson chooses to eat frequent snacks, and still is consuming a nutritionally adequate diet, then there is no reason to complete the RAP in its entirety at each full assessment. In this example, clearly document the initial nutritional assessment including: preferences, information that confirms her diet is sufficient, any supporting weights or any lab values that give insight into nutrition. If she continues to trigger this RAP for the same reasons, make a one line entry referring to the original nutritional assessment and indicate that the resident's status has not changed. **On subsequent assessments, it is always necessary to assess the resident to validate that his or her status has not changed as compared to the original RAP assessment and documentation.**

Q: "Is it required to write a summary note documenting all of the RAP information?"

A: The requirement is that you document information from the resident's assessment and staff's decision making about care. This should already be an easily accessible part of the medical record, in which case a summary note may be redundant. Ask yourself this question: "If I was a newly hired care giver for this resident, will I be able to find and understand the

assessment and decision making process?" If the answer is yes, then you should feel secure that your documentation is complete. If you answer no, consider pulling together key information or "filling in the gaps" in a short note.

Q: "I often hear different stories about what is required for RAP documentation. These stories seem to vary by nursing home, surveyors, care givers, books, software and even the day of the week! Why is that, and how can we find out what is expected in our written documentation?"

A: While interpretations of HCFA's requirements have varied, the RAP process was developed to reflect good clinical practice and RAP documentation expectations have never changed: RAPs guide further assessment of residents who have or are at risk of developing problems (triggered areas). This assessment is supposed to lend further insight into the problems identified by the MDS. RAP "documentation" involves only what should already be taking place: clearly written assessments, decision making by staff knowledge about the resident's condition, and care plans developed based on a comprehensive assessment of a resident's needs, strengths, and preferences.

Where staff often go astray is in the basics. What does clear documentation and decision making mean? The RAP guides the assessment piece and documentation should follow. Decision making is a written account of the team's clinical thought processes about the resident assessment findings. This seemingly simple process has left many people baffled and searching for "user friendly" alternatives to RAP documentation. As a result an industry of workbooks, flow sheets, check lists and software has been created. In some cases, these products may help staff by providing structure that facilitates the clinical assessment and decision-making process; in other cases, such products have tended to create a larger paper trail and made the process more complicated than necessary. Each facility should establish a documentation process that "works" for them and incorporate additional tools only if they are deemed of clear benefit in facilitating documentation and clinical decision-making.

Q: "I don't see how we can possibly do the Urinary Incontinence RAP in 14 days after admission. And, it seems everyone has a different idea about when these RAPs are due. Some say 7 days after admission, 14 days, 21 days, who is right?"

A: Statutory requirements dictate that the RAI be completed within 14 days after admission. As an integral part of the RAI, RAPs must be completed within 14 days, which means that the initial RAP Guideline review must be conducted and documented by the end of that time. However, the RAPs may point out the need for a more extensive evaluation which cannot be completed entirely within the time period. A good example is the Urinary Incontinence RAP. It is generally difficult to perform a complete work-up in 14 days. Even getting initial tests ordered and scheduled can take several weeks. Rather what is intended by "14 days after admission" is when the initial RAP assessment process and documentation must be completed. Certainly you do not wait several weeks to initiate the assessment and make care planning decisions. These initial plans should be outlined in the care plan along with the plan for further assessment.

Q: "Is the person who signs the 'Signature of RN Coordinator for RAP Assessment Process on the RAP Summary form, the same person as the MDS RN Coordinator? What dates are entered in #2 and #4 on the RAP Summary form, and whose name is placed in the 'Signature of Person Completing Care Planning Decision'?

A: The "Signature of RN Coordinator for RAP Assessment Process" does not need to be the same RN as is on the MDS assessment. The date entered in VB2 on the RAP Summary form is the date the RN Coordinator of the RAP process (i.e., the person who oversaw completion of the RAPs), indicated the triggered RAPs and completed the Location and Date of RAP Assessment Documentation section. This must be completed no later than 14 days after admission. The (Signature of) Person Completing Care Planning Decision can be any person(s) who facilitates the care planning decision-making. It is an interdisciplinary process. The care plan must be done no later than 21 days after admission or 7 days after MDS and RAPs are completed. The care-planning information on the RAP Summary form would be completed at that time, with the date to enter in #4 the day that #3 is signed.

4.9 When is the Resident Assessment Instrument not Enough?

Federal requirements support a facility's ongoing responsibility to assess a resident. The Quality of Care regulation[3] requires that "each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care". Services provided or arranged by the facility must also meet professional standards of quality. Compliance with these regulations requires that the facility monitor the resident's condition and respond with appropriate careplanning interventions.

The MDS is a screening instrument and does not include detailed descriptions of all factors necessary for careplanning and evaluation. When completing the MDS, the assessor simply indicates whether or not a factor is present. For certain clinical situations, if the MDS indicates the presence of a potential resident problem, need, or strength, the assessor may need to investigate and document the resident's condition in more detail. For example, if a resident is noted as having a contracture on the MDS, additional documentation in the record may include the number of contractures present, sites, and degree of restriction in each affected joint. RAPs also assist in gathering additional information for some clinical conditions.

In addition, completion of the MDS/RAPs does not necessarily fulfill a facility's obligation to perform a comprehensive assessment. Facilities are responsible for assessing areas that are relevant to individual residents regardless of whether or not the appropriate areas are included in the RAI. For example, the MDS includes a listing of those diagnoses that affect the resident's functioning or needs in the past 7 days. While the MDS may indicate the presence of medical

[3] 42 CFR 483.25–(F 309)

Haldol to p.o. and will slowly decrease the dosage. Continue with Bactrim DS until course completed. Discontinue Zantac. It is unclear why he was started on it and it may be contributing to his confusion. Monitor Intake and Output for next 7 days. I will do a further exam of Mr. S. on Monday.

Day 4 **(The following is an example of a dialogue between the nurse and the social worker about what was learned in admission examinations. It does not represent documentation but serves to illustrate the interdisciplinary assessment processes. Also included on this day are the follow-up nursing notes and a separate physical therapy note. Staff's awareness of the needs and treatments for the resident is expanding.)**

SOCIAL WORKER (SW):

"I spoke with Mr. S., his wife Marion and oldest daughter, Susan, the first two days of admission. Throughout the conversation, Mr. S. was unable to answer simple questions. He was easily sidetracked and would become consumed with smoothing out his bedclothes. Marion and Susan said that normally he can't answer simple questions about his immediate needs, but he can talk endlessly about woodworking and opera."

NURSE (N):

"Mr. S. is much clearer today. Although he didn't remember meeting me before, he responded to his name, and stated that he was not in his home, but in an old person's home. His wife was present and he called her by her proper name."

SW: "Mary [the nurse on evenings] told me that his cognition will probably continue to improve once his delirium clears. I have shared this with the family who seemed relieved."

N: "She is probably right. The UTI, dehydration, morphine, Zantac and Haldol probably contributed to his acute confusion, but because he has Alzheimer's disease, it makes it difficult to assess his baseline."

SW: "Well, his family described a gregarious man, who enjoyed attending the Alzheimer's Day Care Program at the community center. He was diagnosed with Alzheimer's Disease five years ago although the daughter stated that she felt that he was having problems several years before the actual diagnosis. His wife also told me that Mr. S. was having increasing difficulties with his ADLs. She would have to break tasks down into sub-tasks. He required lots of cueing for dressing especially."

N: "He had his admission physical exam yesterday. Under the circumstances, everything seems O.K. His enlarged prostate probably causes some urinary retention which would have put him at greater risk for the urinary tract infection, but his surgical incision line was clean. He appears well hydrated, and the nurse assistants from the day and evening shift indicate that he is taking in ample fluids. He continues to manipulate bed clothes, which according to his wife is a new activity, but it is tapering off. This could represent

a resolution of his acute confusion. We will continue to monitor his intake and output, and cognition in light of his acute confusion. He is at risk for falling. He still has a few more days on his antibiotic for his UTI. The physical therapist will be seeing him today in fact. I'm going to write a brief note to document the areas we covered in these conversations."

NURSING NOTE

Discussed Mr. S.'s condition with Social Worker. Mr. S. seems to be "clearer today". He is oriented to person, able to identify wife by her correct name, and is aware that he is not in his home. He identifies his property that his wife brought in from home (picture and opera posters), and his fidgeting with the bedcloths has lessened. As his acute confusion improves we should see a returning to baseline. On exam Mr. S. appeared well hydrated, I/O adequate according to reports from nurse assistants. He appears in mild discomfort only when he ambulates, and is receiving Tylenol regularly. His dose of Haldol is being slowly tapered. He does not appear to have any negative effects from this. K. Phillips, R.N.

PHYSICAL THERAPY NOTE

On August 14, 1995, he sustained the fall and fractured his left hip. He underwent a successful replacement of the hip, and was cleared for light weight bearing status on 8/21/95. Because of his worsening cognition, and additional problems, he has not been ambulating except out of bed to the commode with nursing staff.

According to the daughter, who was involved with his care at home, his fall was an isolated event. Usually he ambulates around his home, Adult Day Care, and takes frequent walks without event. Orthostatic blood pressures and pulses from the end of his hospitalization and since admission here have been within normal limits, with orthostatic changes noted upon admission to the hospital.

His fall at home occurred at 2 am. The resident was very restless the entire day. He appeared to be having difficulty urinating. His wife was planning to take him into the doctor's office in the morning. Mr. S. got out of bed and was found wandering around the house. His wife tried to get him to return to bed, but he went into the bathroom, got into the shower - with his clothing on - and fell. Wife is not certain if he slipped or just fell.

Upon examination, he did not have orthostatic changes in his blood pressure or heart rate from a lying to upright position. He was able to get out of bed to a standing position with contact guard. Using his new walker, he was able to move to the hallways - safely. He did seem confused about the walker, but followed my commands appropriately.

This resident is ready to bear full weight. Staff should walk with him three times a day using contact guard and cueing for the walker. A sign that reads "Mr. S. remember your pusher" (his word for walker) was placed by his bed and by the inside of the door. According to notes from the Cognitive Impairment Clinic, he is able to read and follow simple written directions.

Assessment: Mr. S. is at risk for future falls due to his recent fracture and hip replacement, cognitive impairments, new required use of walker (which he may get to a point that he doesn't need), and residual acute confusion. Plan: Monitor closely, contact guarding with all ambulation. Ambulate in hallway at least three times a day. Slowly increase distance, over the next two weeks, from room to dining room. J. Smith, P.T.

Day 5 (Example of documentation of additional information gathered that would be relevant to comprehensive resident assessment using the MDS and RAPs)

NURSING NOTE

Resident incontinent of urine all three shifts since admission. His normal pattern at home was to toilet himself as needed, with additional reminders from his wife before leaving the house and at bed time. Resident with a past history of enlarged prostate and urinary retention. Resident is moving his bowels daily and passing moderate amounts of soft, formed stool. Digital exam is negative for feces in rectum. Mr. S. is receiving tapering doses of Haldol. We expect the incontinence to resolve with diminishing Haldol doses, full treatment of UTI, and resolution of delirium. The decision was made to document bowel and bladder activity, I/O of fluids, assess for bladder distention, discuss with wife regarding past patterns for bathroom cueing, and to continue to review medications: Haldol, Bactrim DS.

K. Phillips, R.N.

2. DRAWING INFORMATION TOGETHER

The above are examples of the types of activities and dialogue that occur as staff gather information and structure care during the first few days of a resident's stay in the home. Using this and other information, staff would next fill out the MDS. Each discipline would complete their assigned portion of the MDS, cross check the assessment across disciplines and shifts for accuracy, and then have it signed off by the RN.

A completed MDS for Mr. S. follows. Note that this completed MDS form includes information presented in the examples above, as well as other information not available to the reader. In reviewing Mr. S.'s MDS, note the information that it contains for use by staff in using the RAP Guidelines.